Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

## I. DISPUTE

1. a. Whether there should be reimbursement of $723.00 for dates of service 11/05/01 and 11/09/01.

   b. The request was received on 01/25/02.

## II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and undated Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. Letter to Compliance and Practice dated 01/22/02
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and undated Response to a Request for Dispute Resolution
   b. HCFA(s)
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (4), the Division forwarded a copy of the requestor's additional documentation to the carrier on 05/03/02. The respondent did not respond to the additional documentation. Their initial response is reflected in Exhibit II.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

## III. PARTIES' POSITIONS

1. Requestor: The requestor states in undated correspondence, "The carrier failed to submit payment or denial to this facility….Attached you will find copies of our FedEx confirmation sheets for all our claims….We submitted a request for pre-authorization and were approved by the professionals in the carrier's preauthorization department….We believe the carrier does not submit an EOBM as a stalling tactic to delay the reimbursement process."

2. Respondent: The respondent representative states in undated correspondence, "Response: Carrier never received HCFA 1500 from Provider for Payment. EOBs not submitted, due to bills not being processed."

## IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 11/05/01 and 11/09/01.

2. The provider sent a letter to TWCC Compliance and Practice dated 01/22/02 stating, "Carrier has not submitted payment or a denial of payment on the services provided."

3. The following table identifies the disputed services and Medical Review Division's rationale:

| DOS | CPT or Revenue CODE | BILLED | PAID | EOB Denial Code(s) | MAR$ | REFERENCE | RATIONALE: |
|---|---|---|---|---|---|---|---|
| 11/05/01<br>11/09/01 | 97110<br>97110 | $140.00<br>$140.00 | $0.00<br>$0.00 | No EOB<br>No EOB | $35.00 per 15 min | MFG MGR (I) (A) (9) (b); (I) (A) (10) (a); CPT descriptor | MFG MGR (I) (A) (9) (b) states, "Procedures (Supervision by the doctor or HCP, in either a group (97150) or one-to-one (97110-97139) setting, is required)."<br>(I) (A) (10) (a) states, "A physical session is defined as any combination of four modalities…procedures (97110-97150) and/or physical medicine activities and training…" The maximum amount of time allowed per session is two hours."<br>CPT code 97110 is a one-to-one, timed code.<br><br>Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. The Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. |

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| | | | | | | | Except for slight differences, the provider's SOAP notes word for word through out the lengthy paragraphs.<br><br>The provider presented numerous reasons for the claimant's need for 97110 one-to-one therapeutic exercises. These notes are documented the same for both dates of service. "(Claimant) was prescribed one-on-one therapeutic exercises for one or more of the following reasons. One of the reasons why Dr…,DC, was present during every minute of the therapeutic exercises in the 800 square foot gym with the state of the art exercise equipment and treadmills, was because the patient has never had any formalized training academically or non-academically….Dr…,DC, had to be present supervising (claimant) and her one-on-one rehab technician so if any questions arise by (claimant) for the many problems that occur during stretching, vigorous therapeutic exercise, and cardiovascular exercise there might be a well informed health care provider present to answer them." The need for the claimant to ask a question is not a medical criteria for a one-on one session. Because the claimant does not have "academically or non-academically training" in reference to the "800 square foot gym" does not warrant one-on-one therapeutic sessions. The claimant can be acclaimated to the gym in a group setting. The size of the gym has no medical consequence on the claimant's medical heath care or the need for one-to-one training. The provider failed to produce any medical evidence as to why the claimant would require one-to-one therapeutic exercises.<br><br>The provider stated, "The reasons why this one-on-one care was given and not the group session are because the treating physician took different factors into consideration. Reasons like, (claimant) needed one-on-one care provided by…because at times several patients are using the treadmill, cardiovascular equipment, and other therapeutic equipment causing them to have shortness of breath which may lead to cardiac arrest." The medical records submitted by the provider do not document any type of cardiovascular problems for the claimant. Further in the SOAP notes for 11/05/01, the claimant reportedly walks 4593 feet on a treadmill in 20 minutes. On 11/09/01, the claimant walked 3645 feet on the treadmill in 20 minutes. A mile is 5,280 feet. On 11/05/01 and 11/09/01, the provider prefaces the treadmill workout by, "…she started to do cardiovascular endurance exercises….after successful completion…with no apparent complications, she progressed to an intermediate and then to a normal cardiovascular workout." With the documentation of the claimant progressing from an intermediate to a normal cardiovascular workout of such intensity, there should be no medical reason for one-to-one or fear of a "cardiac arrest". |

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| | | | | | | | The provider also states another reason for one-to-one sessions is, "…so that she would not re-injure herself. (Claimant) has injury to her tissue structures and if this is not watched carefully by the individualized attention then the chance for a more severe injury is highly probable." If the provider is that concerned about the fragility of the claimant's injury that "if this is not watched carefully by the individualized attention then the chance for a **more severe injury is highly probable**" (bolded for emphasis), then the provider should re-evaluate the claimant's treatment plan and decrease the strenuous activities the provider has the claimant doing. The statement , "chance for a more severe injury is highly probable" is subjective without specific medical causation. The provider failed to **medically** (bolded for emphasis) describe **what** (bolded for emphasis) would happen to the claimant's tissue injury and **medically** (bolded for emphasis) describe **how** (bolded for emphasis) the claimant would re-injure herself. The provider failed to substantiate any medical condition or symptom which the claimant presented that would mandate one-on-one supervision for an entire session or over an entire course of treatment.<br><br>The notes do not reflect the need for one-on one supervision tapering off over time as the claimant becomes more familiar with the exercises. There are no direct statements as to whether a physical therapist was conducting the one-on-one sessions.<br>Although the provider's SOAP notes indicate activities and time frames, the narratives are not clearly written to reconcile the times documenting the activities with the times billed on the HCFA(s).<br>The therapy sessions are not signed.<br><br>**No** reimbursement is recommended. |

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| 11/05/01<br>11/09/01 | 97113<br>97113 | $208.00<br>$208.00 | $0.00<br>$0.00 | No EOB | $52.00 per 15 min | MFG MGR (I) (A) (9) (b); (I) (A) (10) (a); CPT descriptor | MFG MGR (I) (A) (9) (b) states, "Procedures (Supervision by the doctor or HCP, in either a group (97150) or one-to-one (97110-97139) setting, is required)."<br>(I) (A) (10) (a) states, "A physical session is defined as any combination of four modalities…procedures (97110-97150) and/or physical medicine activities and training…" The maximum amount of time allowed per session is two hours."<br>CPT code 97113 is a one-to-one, timed code.<br><br>Recent review of disputes involving CPT code 97113 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. The Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation.<br><br>The provider fails to document or substantiate any medical condition or symptom which the claimant presents that mandates one-on-one supervision for an entire session. The notes do not reflect the need for one-on one supervision tapering off over time as the claimant becomes more familiar with the exercises. There are no direct statements as to whether a physical therapist was conducting the one-on-one sessions. Although the provider's SOAP notes indicate activities and time frames, the narratives are not clearly written to reconcile the times documenting the activities with the times billed on the HCFA(s).<br>The therapy sessions are not signed.<br><br>**No** reimbursement is recommended. |
| 11/05/01<br>11/09/01 | 99211<br>99211 | $18.00<br>$18.00 | $0.00<br>$0.00 | No EOB | $18.00 | MFG E/M (II); CPT descriptor | The medical documentation for CPT code 99211 in dispute appears to be for physical therapy rendered; however, as no signature is noted on the medical documentation, it us unclear if this a physical, occupational therapist evaluation evaluation or an additional physician's visit. The MFG ground rules indicate when there is concurrent care, it should be coordinated by the treating doctor, and the necessity of the concurrent care be documented. It also states that modifier -75 should be used. The -75 modifier was not used in the billing.<br><br>**No** reimbursement is recommended. |
| **Totals** | | $732.00 | $0.00 | | | | The Requestor **is not** entitled to reimbursement. |

The above Findings and Decision are hereby issued this 26th day of June, 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.